UNITED STATES DISTRICT COURT

for the

Northern District of Georgia

Atlanta Division

Case No. 1:23-CV-0982

(to be filled in by the Clerk's Office)

KARDARIus KANTREZ GLASS

Plaintiff(s)

(Write the full name of each plaintiff who is filing this complaint. If the names of all the plaintiffs cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

-v-

DFCS - Food Stamps

Defendant(s)

(Write the full name of each defendant who is being sued. If the names of all the defendants cannot fit in the space above, please write "see attached" in the space and attach an additional page with the full list of names.)

Jury Trial: *(check one)* ☐ Yes ☐ No

COMPLAINT FOR A CIVIL CASE

I. The Parties to This Complaint

A. The Plaintiff(s)

Provide the information below for each plaintiff named in the complaint. Attach additional pages if needed.

Name: KARDARIus KANTREZ GLASS
Street Address: 805 MAGNOLIA WAY, NW
City and County: Atlanta, GA, 30314
State and Zip Code:
Telephone Number:
E-mail Address:

B. The Defendant(s)

Provide the information below for each defendant named in the complaint, whether the defendant is an individual, a government agency, an organization, or a corporation. For an individual defendant, include the person's job or title *(if known)*. Attach additional pages if needed.

Defendant No. 1

Name: DFCS - DEKALB CNTY MAIN DFCS

Job or Title *(if known)*

Street Address: 2300 PARKLANE DRIVE

City and County: ATLANTA, GA, 30345

State and Zip Code

Telephone Number

E-mail Address *(if known)*

Defendant No. 2

Name

Job or Title *(if known)*

Street Address

City and County

State and Zip Code

Telephone Number

E-mail Address *(if known)*

Defendant No. 3

Name

Job or Title *(if known)*

Street Address

City and County

State and Zip Code

Telephone Number

E-mail Address *(if known)*

Defendant No. 4

Name

Job or Title *(if known)*

Street Address

City and County

State and Zip Code

Telephone Number

E-mail Address *(if known)*

II. Basis for Jurisdiction

Federal courts are courts of limited jurisdiction (limited power). Generally, only two types of cases can be heard in federal court: cases involving a federal question and cases involving diversity of citizenship of the parties. Under 28 U.S.C. § 1331, a case arising under the United States Constitution or federal laws or treaties is a federal question case. Under 28 U.S.C. § 1332, a case in which a citizen of one State sues a citizen of another State or nation and the amount at stake is more than $75,000 is a diversity of citizenship case. In a diversity of citizenship case, no defendant may be a citizen of the same State as any plaintiff.

What is the basis for federal court jurisdiction? *(check all that apply)*

☐ Federal question ☐ Diversity of citizenship

Fill out the paragraphs in this section that apply to this case.

A. If the Basis for Jurisdiction Is a Federal Question

List the specific federal statutes, federal treaties, and/or provisions of the United States Constitution that are at issue in this case.

Corruption / Pain and Suffering

B. If the Basis for Jurisdiction Is Diversity of Citizenship

1. The Plaintiff(s)

a. If the plaintiff is an individual

The plaintiff, *(name)* _____, is a citizen of the State of *(name)* _____.

b. If the plaintiff is a corporation

The plaintiff, *(name)* _____, is incorporated under the laws of the State of *(name)* _____, and has its principal place of business in the State of *(name)* _____.

(If more than one plaintiff is named in the complaint, attach an additional page providing the same information for each additional plaintiff.)

2. The Defendant(s)

a. If the defendant is an individual

The defendant, *(name)* _____, is a citizen of the State of *(name)* _____. Or is a citizen of *(foreign nation)* _____.

b. If the defendant is a corporation

The defendant, *(name)* _____, is incorporated under the laws of the State of *(name)* _____, and has its principal place of business in the State of *(name)* _____.

Or is incorporated under the laws of *(foreign nation)* _____, and has its principal place of business in *(name)* _____.

(If more than one defendant is named in the complaint, attach an additional page providing the same information for each additional defendant.)

3. The Amount in Controversy

The amount in controversy–the amount the plaintiff claims the defendant owes or the amount at stake–is more than $75,000, not counting interest and costs of court, because *(explain)*:

III. Statement of Claim

Write a short and plain statement of the claim. Do not make legal arguments. State as briefly as possible the facts showing that each plaintiff is entitled to the damages or other relief sought. State how each defendant was involved and what each defendant did that caused the plaintiff harm or violated the plaintiff's rights, including the dates and places of that involvement or conduct. If more than one claim is asserted, number each claim and write a short and plain statement of each claim in a separate paragraph. Attach additional pages if needed.

Corruption - The Stystm is not working!!!

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IV. Relief

State briefly and precisely what damages or other relief the plaintiff asks the court to order. Do not make legal arguments. Include any basis for claiming that the wrongs alleged are continuing at the present time. Include the amounts of any actual damages claimed for the acts alleged and the basis for these amounts. Include any punitive or exemplary damages claimed, the amounts, and the reasons you claim you are entitled to actual or punitive money damages.

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V. Certification and Closing

Under Federal Rule of Civil Procedure 11, by signing below, I certify to the best of my knowledge, information, and belief that this complaint: (1) is not being presented for an improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation; (2) is supported by existing law or by a nonfrivolous argument for extending, modifying, or reversing existing law; (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discovery; and (4) the complaint otherwise complies with the requirements of Rule 11.

A. For Parties Without an Attorney

I agree to provide the Clerk's Office with any changes to my address where case–related papers may be served. I understand that my failure to keep a current address on file with the Clerk's Office may result in the dismissal of my case.

Date of signing: 3/2/23

Signature of Plaintiff KARDarius K. GLASS

Printed Name of Plaintiff KARDARIUS KANTREZ GLASS

B. For Attorneys

Date of signing: _____

Signature of Attorney _____

Printed Name of Attorney _____

Bar Number _____

Name of Law Firm _____

Street Address _____

State and Zip Code _____

Telephone Number _____

E-mail Address _____

Division of Family and Children Services

Application for Benefits

(Keep these documents for your information)

What Do the Words Used in this Application Mean?

This chart explains the words we have used in this application.

Applicant	An individual who applies to receive public assistance or benefits.
Assistance Unit (AU)	An assistance unit includes *eligible* individuals who live together and receive public assistance/benefits.
Caretaker	A parent, relative or legal guardian who applies for and receives TANF with children in his or her care.
Disqualified	The action taken to remove an individual from a Food Stamp (SNAP) or TANF case because they did not tell the truth and received benefits that they should not have received.
Electronic Benefit Transfer (EBT)	The system used in Georgia to pay benefits to individuals who are eligible for Food Stamps (SNAP). Individuals receiving assistance are issued an EBT debit card, which is used to access their Food Stamp (SNAP) accounts.
Electronic Communications	You have the option to choose how you would like to receive notifications about your information. If you choose to receive email or text notifications, you will receive a message notifying you that you have a notice in My Notices located in GA Gateway Customer Portal. For Email Communication, you must provide us with your email address and accept the terms and conditions for paperless notices located in GA Gateway Customer Portal after you create an account. Please visit the GA Gateway Customer Portal Website at www.gateway.ga.gov to update your notification settings. For Texting Communication, you must provide us with your phone number. Standard message and data rates may apply. This may vary by carriers, please check with your provider.
EPPICard debit MasterCard	The State of Georgia has implemented a convenient "electronic" payment option for the TANF recipients called the EPPICard debit MasterCard. Under this payment option, money is deposited in the recipient's account on the first calendar day of the month. If the first falls on a weekend or holiday, benefits are made available on the last business day of the prior month. The recipient has immediate access to his or her funds because the funds are electronically loaded to the debit MasterCard.
Grantee Relative	A parent, relative or legal guardian who applies for and receives TANF in his or her name on behalf of the children.
Gross Income	A person's total income before taking taxes or other deductions into account.
Household Members	Individuals who live in your home. For Food Stamps (SNAP), individuals who live together and purchase and prepare their meals together.
Income	Payments such as wages, salaries, commissions, bonuses, worker's compensation, disability, pension, retirement benefits, interest, child support or any other form of money received.
Middle Class Tax Relief Act of 2012	This Act prohibits the use of cash assistance funds or TANF Debit Cards to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities, poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, racetracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons. The use of cash assistance funds or the TANF Debit Card at these businesses will constitute an intentional program violation (fraud) on the part of the recipient.
Migrant Farm Workers	Individuals who are seasonal farm workers and who move from one home base to another to work or look for farm work.
Non-applicant	An individual who does NOT apply for or receive public assistance/benefits. Non-applicants are not required to provide a social security number, citizenship, or immigration status.

Qualified Alien/Immigrant	A *qualified alien/immigrant* is a person who is legally residing in the U.S. who falls within one of the following categories: • a person *lawfully admitted for permanent residence* (LPR) under the Immigration and Nationality Act (INA); • *Amerasian* immigrant under section 584 of the Foreign Operations, Export Financing and Related Program Appropriations Act of 1988; • A person who is *granted asylum* under section 208 of the INA; • *Refugees*, admitted under section 207 of the INA; • A person *paroled* as a refugee or asylee under section 212 (d)(5) of the INA; • A person whose *deportation* is being withheld under section 243(h) of the INA as in effect prior to April 1, 1997, or section 241(b)(3) of the INA, as amended; • A person who is *granted conditional entry* under section 203(a)(7) of the INA as in effect prior to April 1, 1980; • *Cuban or Haitian* immigrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980; • *Victims of human trafficking* under section 107(b)(1) of the Trafficking Victims Protection Act of 2000; • *Battered immigrants* who meet the conditions set forth in section 431 (c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended; • *Afghan or Iraqi* immigrants granted special immigrant status under section 101(a)(27) of the INA (subject to specified conditions); • *American Indians* born in Canada living in the U.S. under section 289 of the INA or non-citizens of federally recognized Indian tribe under Section 4(e) of the Indian Self-Determination and Education Assistance Act and; • *Hmong or Highland Laotian tribal members* that rendered assistance to U.S. personnel by taking part in military or rescue operation during Vietnam Era (8/05/1964 – 5/07/1975). For Medical Assistance applicants only, Compact of Free Association (COFA) are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands and the Republic of Palau. COFA migrants do not have to meet the 5-year bar.
Resources	Cash, property, or assets such as bank accounts, vehicles, stocks, bonds, and life insurance.
Seasonal Farm Workers	Individuals who work at certain times of the year planting, picking, or packing produce. They are hired on a temporary basis when a job requires more workers than the farm employs on a regular basis.
Trafficking in the Food Stamp (SNAP) Program	*Trafficking* SNAP benefits means: (1) Buying, selling, stealing, or otherwise exchanging SNAP benefits issued and accessed via EBT cards, card numbers and PIN numbers or by manual voucher and signature, for CASH or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone; (2) The exchange of firearms, ammunition, explosives, or controlled substances; (3) Purchasing a product with SNAP benefits that has a container requiring a return deposit with the intent of obtaining cash by discarding the product and returning the container for the deposit amount, intentionally discarding the product, and intentionally returning the container for the deposit amount; (4) Purchasing a product with SNAP benefits with the intent of obtaining cash or consideration other than eligible food by reselling the product, and subsequently intentionally reselling the product purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (5) Intentionally purchasing products originally purchased with SNAP benefits in exchange for cash or consideration other than eligible food; (6) Attempting to buy, sell, steal, or otherwise affect an exchange of SNAP benefits issued and accessed via Electronic Benefit Transfer (EBT) cards, card numbers and personal identification numbers (PINs), or by manual voucher and signatures, for cash or consideration other than eligible food, either directly, indirectly, in complicity or collusion with others, or acting alone.

For All Medicaid Applicants:

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector General at (local) (404) 463-7590 or (toll free) (800) 533-0686; by email at oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5th Floor, Atlanta, GA 30303; or visit https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

ivision of Family and Children Services

Application for Benefits

YOU MUST HAND DELIVER, FAX or MAIL THE COMPLETED APPLICATION TO YOUR LOCAL COUNTY OFFICE.

If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

What Services Do We Offer at the Division of Family and Children Services (DFCS)?

DFCS offers the following services:

Food Assistance

Food Stamp (SNAP) benefits can be used to buy food at any store that has the EBT/*Quest* sign. We will subtract the price of your food purchase from your Food Stamp (SNAP) account.

Cash Assistance/Employment Support Services

Temporary Assistance for Needy Families (TANF) provides cash assistance to families with dependent children for a limited time. Parents or caretakers who are included in the grant are required to participate in a work program. The Cash Assistance program also provides financial assistance to refugee households who are not eligible for the TANF program.

- **Grandparents Raising Grandchildren (GRG)** will provide the support necessary so that children can be cared for in the homes of their grandparents.

Medical Assistance

Medicaid, for those who are eligible, may help pay medical bills, doctor's visits, and Medicare premiums.

Community Outreach Services

For more information about other DHS services, please visit our website at http://dfcs.georgia.gov or call (877) 423-4746.

How Do I Apply for Benefits?

Step 1. Fill out the application.

Read the questions carefully and give accurate information. Sign and date the application.

Step 2. Turn in the application to your local office.

You will need to tear off pages 1-2, 17-20 and keep them for yourself.

Mail, fax, or bring in pages 3-16 of this application to your local Division of Family & Children Services (DFCS) office. You can locate your local office at http://dfcs.georgia.gov/locations .

If you or the person for whom you are applying is eligible for benefits, Food Stamp (SNAP) benefits will be provided from the date we receive the application with your name, address, and signature on it. TANF benefits will be provided from the date the application is approved.

Frequently Asked Questions

How long does it take to get benefits?

Food Stamps (SNAP):	up to 30 days
TANF:	up to 45 days
Medicaid:	10 to 60 days

You may be able to get Food Stamps (SNAP) within 7 days if you qualify. See page 6.

How much will I get?

Your income, resources, and family size determine benefit amounts. We will be able to give you specific information once we determine your eligibility.

How will I get my benefits?

For Food Stamps (SNAP), you will get an Electronic Benefit Transfer (EBT) card to access your benefits. For TANF, you will get an EPPIC Debit Master card to access your benefits. For Medicaid, you will receive a Medicaid card for each eligible member.

You may be asked to provide the following information:

- Proof of identity for the applicant if applying for Food Stamps (SNAP) and/or TANF. An identification card (ID) or driver's license (DL) is an acceptable form of verification. Proof of Identity is not required for Medical Assistance applicants.
- Proof of US citizenship/qualified immigrant status for everyone requesting benefits. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.
- Social Security numbers of everyone requesting assistance.
- Proof of income *for example*, pay stubs, child support payments, and income award letters. Proof of child support payments is not needed for Medical Assistance applicants.
- Proof of expenses like childcare receipts, medical bills, medical transportation costs, rent/mortgage costs, and child support payments. This information is not required for Medical Assistance applicants.

We will first attempt to verify citizenship/immigration status and income information through electronic data sources. Paper verification documents are not required to submit an application; however, you may provide the documents with the application. If we are unable to verify through electronic data sources and you need help getting this information, please tell us.

Division of Family and Children Services

Application for Benefits

If you are applying for Food Stamps (SNAP), TANF and/or Medicaid, you can file an application for benefits with only your name, address, and signature. However, it may help us to process your application quicker if you complete the entire form. You may use this form to file a joint application for more than one program or for the Food Stamp (SNAP) program only. Your (SNAP) application will not be denied solely on the basis that your application for another program has been denied. We will make a separate eligibility determination for your Food Stamp (SNAP) application. If you are in an institution and applying for Food Stamps (SNAP) and SSI at the same time, the filing date of your application is the date you are released from the institution.

Step 3. Talk with us.
You may need to complete an interview with a worker. If so, we will give you an appointment. This interview can be completed by phone.

How do we use the applicant's personal information?

You only have to provide Social Security Numbers (SSN) and citizenship or immigration status for persons who want to apply for benefits. This information will be used to check the income and eligibility verification system (IEVS). We will also match your information against other Federal, state and local agencies to verify your income and eligibility, to track wage information and participation in work activities. I a household member does not want to give us information about their SSN, citizenship or immigration status, other household members may still receive benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status.

Can someone else apply for me?
For Food Stamps (SNAP) and Medicaid, you may ask someone to apply for you.
For TANF, anyone can apply but the parent or caretaker must be interviewed.

Division of Family and Children Services

Application for Benefits

(Complete this application and return it to your LOCAL COUNTY DFCS office.)

What Am I Applying For? (Check all that apply)

☑ **Food Stamps (Supplemental Nutrition Assistance Program (SNAP))**
The Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps, is a federally funded program that provides monthly benefits to low-income households to help pay for the cost of food. The program also provides nutrition education to families to meet their food and nutritional needs and provides employment and training opportunities to help families gain employment that leads to less dependence on SNAP.

☐ **Temporary Assistance for Needy Families (TANF)**
Temporary Assistance for Needy Families (TANF) provides temporary monthly cash payments, single cash payments, or other support services, to strengthen eligible families with children. If you are the child's parent, or the caretaker who would like to be included in the grant, we will require you to participate in a work program.

☐ **Grandparents Raising Grandchildren (GRG)**
Grandparents Raising Grandchildren (GRG) will provide additional cash payments so that children can be cared for in the homes of their grandparents. **Applicants must apply for TANF to be eligible for GRG.**

☐ **Refugee Cash Assistance**

The Refugee Cash Assistance program provides financial assistance to refugee households who are not eligible for the TANF program. The term refugee includes refugees, Cuban/ Haitian Entrants, victims of human trafficking, Amerasians, Asylees, Afghanis or Iraqis with Special Immigrant Visa (SIV) or eligible Afghan parolees.

☐ **Medicaid**
Medicaid offers medical coverage to elderly, blind or disabled adults, pregnant women, children, and families. When you apply, we will look at all Medicaid programs and decide which ones you may be eligible to receive.

Please fill out the chart below about the applicant.

First Name	Middle Initial	Last Name	Suffix
Kardrius	K.	Glass	
Street Address Where You Live		**Apt**	
805 MAGINOLA WAY NW		101	
City	**State**	**Zip Code**	
Atlanta	Georgia	30314	
Mailing Address (If different)			
Main Telephone Number	**Other Contact Number**		
770-256-6513			
Electronic Communication: Email: Yes____ or No____ (optional) Texting: Yes____ or No____ (optional)	**Email Address (optional):**		
What is your Preferred Language?	**If an interview is required, will you need an interpreter? Yes____or No____**		

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance (if applicable):

Do you have a disability that will require a Reasonable Modification or Communication Assistance? Yes____ No___
(If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):
Sign Language interpreter____; TTY____; Large Print____; Electronic communication (email)____; Braille_____; Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter___; Telephone call reminder of program deadlines____; Telephonic signature (if applicable)____; Face-to-face interview (home visit)____; Other:_____
Do you need this Reasonable Modification or Communication Assistance one-time____or ongoing ___? If possible, briefly explain when and how long you need this modification or assistance?

_____

Division of Family and Children Services

Application for Benefits

PeachCare for Kids

For All Food Stamp (SNAP), TANF, and Medicaid Applicants:

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to Food Stamp (SNAP) and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of $4250 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my application or renewal process and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my Food Stamp (SNAP) benefits.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

Kadria Kentrez Glass
Signature

3/7/23
Date

Witness Signature if signed by "X"

Date

Authorized Representative:

Complete this section only if you want a person or an organization to fill out your application, complete your interview, and/or use your EBT card to buy food when you cannot go to the store. Please check for each program type who you want to designate as an authorized representative. Please check which duties you want the person or organization to have. If you are applying for Medicaid, you can choose more than one person or organization to act on your behalf.

Authorized Representative 1 Program Types: Food Stamps (SNAP) ☑ TANF ☐ Medical Assistance ☐
Authorized Representative 1 Duties: Sign application on applicant's behalf ☐ Complete and submit renewal form ☐
Receive copies of notices and other communication ☐ Act on behalf of applicant in all other matters ☐
Receive a TANF benefit card (EPPIC) ☐

Person Name 1: _____

Organization Name 1 (if applicable): _____ Phone: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Electronic Communication: Email: Yes ___ No ___ (optional) Texting: Yes ___ No ___ (optional)

Email Address (optional) _____

Preferred Language: _____ Is an interpreter needed? Yes ___or No ___

Division of Family and Children Services

Application for Benefits

Authorized Representative 2 Program Types: Food Stamps (SNAP) ☑ TANF ☐ Medical Assistance ☐
Authorized Representative 2 Duties: Sign application on applicant's behalf ☐ Complete and submit renewal form ☐
Receive copies of notices and other communication ☐ Act on behalf of applicant in all other matters ☐
Receive a TANF benefit card (EPPIC) ☐

Person Name 2: _____
Organization Name 2 (if applicable): _____ Phone: _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Electronic Communication: Email: Yes ___ No ___ (optional) Texting: Yes ___ No ___ (optional)
Email Address (optional) _____
Preferred Language: _____ Is an interpreter needed? Yes ___or No ___

Americans with Disabilities Act: Request for Reasonable Modification & Communication Assistance for Authorized Representatives (if applicable):

Does the Authorized Representative have a disability that will require a Reasonable Modification or Communication Assistance? Yes___ No___ (If yes, please describe the Reasonable Modification or Communication Assistance that you are requesting):

Sign Language interpreter____; TTY____; Large Print____; Electronic communication (email)____; Braille_____; Video Relay____; Cued Speech Interpreter____; Oral Interpreter____; Tactile Interpreter____; Telephone call reminder of program deadlines____; Telephonic signature (if applicable) ____; Face-to-face interview (home visit) ___; Other: _____

Does the authorized representative need this Reasonable Modification or Communication Assistance one-time____or ongoing____? If possible, briefly explain when and how long you need this modification or assistance?_____

For Office Use Only: Date Received:_____

Express Lane Eligibility:

Express Lane Eligibility (ELE) is an automatic process to enroll or renew eligible children under the age of 19 who are receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) into the Medical Assistance program. If your children are eligible for SNAP or TANF, the Division of Family and Children Services (DFCS) will use the household size, residency, and income information from SNAP or TANF, but DFCS will verify citizenship or immigration status using Medical Assistance rules to make an ELE determination to enroll or renew the children in Medicaid or PeachCare for Kids®. If your children are eligible for PeachCare for Kids®, they may be subject to a premium. DFCS will send you a determination notice, let you make any changes and allow you to opt out at any time.

Do you agree to allow DFCS to use your information from SNAP or TANF to make an ELE determination to enroll or renew your children in Medicaid or PeachCare for Kids®?

☐Yes ☐No

Division of Family and Children Services

PeachCare for Kids

Application for Benefits

Do I Qualify to Get Food Stamps (SNAP) Faster? (This information is required for Food Stamp (SNAP) applicants only)

Answer these questions about the applicant and all household members to see if you can get Food Stamps (SNAP) within 7 days

1. Are you or any household member a migrant or seasonal farm worker? ☐ Yes ☑ No

   If **yes**, who _____

2. Total **Gross earned income** that will be received for this month: $ 900
   Employer Name SSI
   Employment Begin Date _____ Employment End Date _____
   Rate of Pay _____ Hours Worked Weekly _____
   How Often Are You Paid: weekly/bi-weekly/semi-monthly/monthly (circle one)

3. Total **Gross unearned income** that will be received for this month: $ 900
   Type of Unearned Income _____ Amount _____
   How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

   Type of Unearned Income _____ Amount _____
   How Often Received: weekly/bi-weekly/semi-monthly/monthly (circle one)

4. Total earned and unearned income for this month: $ 900

5. How much money do you and all household members have in cash or in the bank? $ 0

6. What is the monthly amount of your rent, mortgage, property taxes, and/or homeowner's insurance? $ 500

7. What is the total amount of your electric, water, gas, and/or other utilities this month? $ 60
   (Exclude past due and late fee amounts in the total)

   a. What is your household's primary heating or cooling source? Mark all that apply
      Electric ✓ Gas ____ Window or central air conditioner ____ Kerosene oil ____ Wood ____

   b. Have you received energy assistance in the last 12 months? ☐ Yes ☑ No If **yes**, amount received $ _____

ivision of Family and Children Services

Application for Benefits

Tell Us about the Applicant and All Household Members

For Medical Assistance applicants: Please include yourself, your spouse, your children (including stepchildren) under 21 who live with you, your unmarried partner who needs health coverage, anyone you include on your tax return, even if they do not live with you, and anyone else under 21 who you take care of and lives with you. You do not have to include your unmarried partner who does not need health coverage, your unmarried partner's children, your parents who live with you but file their own tax return (if you are over 21), or other adult relatives who file their own tax return. If you are applying for Emergency Medical Services (EMA) only, you do not have to provide your SSN or information about your immigration status.

Please fill out the chart below about the applicant and all household members. The following federal laws and regulations: The Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, authorize DFCS to request you and your household members social security number(s). Anyone who is living in your household and is not applying for benefits may be treated as a **non-applicant**. Non-applicants do not have to give us information about their social security number, citizenship, or immigration status and are not eligible for benefits. Other household members may still be able to receive benefits if they are otherwise eligible. If you want us to decide whether any household members are eligible for benefits, you will still need to tell us about their citizenship or immigration status and give us their social security number (SSN). You will still need to tell us about **their** income and resources to determine the eligibility and benefit level of the household. We will not report any non-applicant household members to the United States Citizenship and Immigration Services (USCIS) Systematic Alien Verification for Entitlements (SAVE) system if they do not give us their citizenship or immigration status. However, if immigration status information has been submitted on your application, this information may be subject to verification through the SAVE system and may affect the household's eligibility and benefit level. We will match your information with other Federal, state, and local agencies to verify your income and eligibility. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp (SNAP) claim, the information on this application, including SSN, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim. We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status.

NAME First Middle Initial Last	Relationship	Is this person applying for benefits? (Y/N)	Does this person need health coverage? (Y/N)	Birth Date Format (mm/dd/yy)	Social Security Number **(Optional for Non - Applicants)**	Sex (M/F)	Hispanic or Latino? **(Optional)** (Y/N)	Race Code **(Optional)** (See codes Below)	Are you a U.S citizen, U.S. National, qualified immigrant or in a satisfactory immigration status? **(Applicants only)** (Y/N)
ARDARIUS GLASS	SELF	Y	Y	08/07/[illegible]	257-91-4248	M	N	BL	Y

Race Codes (Choose all that apply):
AI - American Indian or Alaska Native **AS** - Asian **BL** – Black or African American
HP - Native Hawaiian or Other Pacific Islander **WH** - White
By providing Race/Ethnicity information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

Division of Family and Children Services

Application for Benefits

PeachCare for Kids

If you or other household applicants are not U.S. Citizens or U.S. Nationals, complete the following chart:
(please add additional pages as needed)

NAME First	Middle Initial	Last	Immigration document type	Alien/Certificate/Document ID number	Have you lived in the U.S. since 1996? (Y/N)	Date Naturalized/Date of Entry or Admission into U.S. (if applicable) Format (mm/dd/yy)	Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? (Y/N)

Tell Us More about the Applicant and All Household Members

We need more information about the applicant and all household members in order to decide who is eligible for benefits. Please answer only the questions about the benefits you want to receive on the page below.

1. Has anyone received any benefits in another county or state? (For Food Stamps (SNAP) and TANF only)
   ☐ Yes ☒ No

   If **yes**:
   Who: _____
   Where: _____
   When: _____

2. Has anyone been convicted of giving false information about where they live and who they are to get multiple FS benefits in more than one area after 8/22/1996? (For Food Stamps (SNAP) only) ☐ Yes ☒ No

   If **yes**:
   Who: _____
   Where: _____
   When: _____

3. Did anyone in your household voluntarily quit a job or voluntarily reduce his/her work hours below 30 hours per week within 30 days of the date of application? (For Food Stamps (SNAP) and TANF only) ☐ Yes ☒ No

   If **yes**, who quit? _____
   Why did he/she quit? _____

4. Is anyone pregnant? (This question does not apply to Food Stamps (SNAP) applicants) ☐ Yes ☒ No

   If **yes**, what is the estimated due date? _____; and how many babies expected? ___
   If no, did anyone in the household deliver or was a pregnancy terminated within the last 12 months? ☐ Yes ☒ No

   If **yes**, what was the delivery/termination date? _____; and how many babies were delivered/expected? ____
   Name of pregnant woman: _____ Unborn baby's father's name: _____
   Father's address: _____

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5. For Medicaid applicants, does anyone have any unpaid medical bills for the last 3 months? ❑ Yes ☒ No
   If **yes**, please send the unpaid bills if you have a Medicaid case.

6. Is anyone disqualified from the Food Stamp (SNAP) or TANF Program? (For Food Stamps (SNAP) and TANF only) ❑ Yes ☒ No

   If **yes**:
   Who: _____
   Where: _____

7. Is anyone fleeing to avoid prosecution or jail for a felony? (For Food Stamps (SNAP) and TANF only) ❑ Yes ☒ No
   If **yes**, who: _____

8. Is anyone violating conditions of probation or parole? (For Food Stamps (SNAP) and TANF only) ❑ Yes ☒ No
   If **yes**, who: _____

9. Does anyone have a felony conviction because of behavior related to the possession, use or distribution of a controlled drug substance (i.e., drug felon) after 8/22/1996 (For Food Stamps (SNAP) and TANF only) or a violent felony (For TANF only)? ❑ Yes ❑ No

   If **yes**:
   Who: _____ When: _____

   a. Are you in compliance with the terms of probation related to any sentence received as a result of a drug felony conviction? (For Food Stamps (SNAP) only) ❑ Yes ☒ No

   b. Are you in compliance with the terms of parole related to any sentence received as a result of a drug felony conviction? (For Food Stamps (SNAP) only) ❑ Yes ☒ No

   c. Have you successfully completed **all the terms of probation or parole** related to any drug related conviction? (For Food Stamps (SNAP) only) ❑ Yes ☒ No

10. Have you or any household member been convicted of trading Food Stamp (SNAP) benefits for drugs after 8/22/1996? (For Food Stamps (SNAP) only) ❑ Yes ☒ No

    If **yes**:
    Who: _____ When: _____

11. Have you or any household member been convicted of buying or selling Food Stamp (SNAP) benefits over $500 after 8/22/1996? (For Food Stamps (SNAP) only) ❑ Yes ☒ No

    If **yes**:
    Who: _____
    When: _____

12. Have you or any household member been convicted of trading Food Stamp (SNAP) benefits for guns, ammunition, or explosives after 8/22/1996? (For Food Stamps (SNAP) Only) ❑ Yes ☒ No

    If **yes**:
    Who: _____
    When: _____

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13. Have you or any member of your household been convicted as an adult of aggravated sexual abuse, murder, sexual exploitation, and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense, after 2/7/2014? (For Food Stamps (SNAP) only) ☐ Yes ☒ No

If **yes**:
Who: _____
When: _____

a. Are you in compliance with the terms of probation related to any sentence received as a result of a felony conviction? (For Food Stamps (SNAP) only) ☐ Yes ☒ No

b. Are you in compliance with the terms of parole related to any sentence received as a result of a felony conviction? (For Food Stamps (SNAP) only) ☐ Yes ☒ No

c. Have you successfully completed **all the terms of probation or parole** related to any felony related conviction? (For Food Stamps (SNAP) only) ☐ Yes ☒ No

14. Have you or any household member received lottery or gambling winnings? ☐ Yes ☒ No

If **yes**:
Who: _____ When: _____ Amount Received: _____

15. Has anyone used TANF funds or the EPPIC Card at the following establishments, liquor stores, casinos, poker rooms, adult entertainment business, bail bonds, night clubs, salons/taverns, bingo halls, racetracks, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons? (For TANF only) ☐ Yes ☒ No

If **yes**:
Who: _____ When: _____

16. Is anyone who is applying for benefits, currently receiving alimony? ☐ Yes ☒ No

If **yes**:
Who: _____
Monthly Amount Received: _____
Date alimony agreement finalized or last modified: _____

Tell Us about the Applicant and All Household Members Income

Do you or anyone who lives in your household receive any type of income such as: wages, tips, bonuses, self-employment, Social Security/Railroad Retirement, other disability, pensions, unemployment, or any other income? For Food Stamps (SNAP) and TANF, please also list income such as: VA income, child support, money from other people or workers compensation. If **yes**, complete the chart below.

Household Member Name with Income	Type of Income	Employer Name /Source of Income	Monthly Amount (Before Deductions)	How Often received (monthly, biweekly, weekly)	Pay Per Hour	Hours per Week	DATE (S) PAID
KARDARIUS GLASS	SSI		900	monthly			1

If self-employed, please list your monthly business expenses amount: $_____

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Application for Benefits

Tell Us about the Applicant and All Household Members Resources - For TANF applicants, list all resources for all household members and Medicaid applicants who are Aged (65 or older), Blind or Disabled (permanent impairment that prevents you from working)

Do you or anyone you are applying for own any resources? ☐ Yes ☐ No
If **yes**, please complete the information below (Check all resources (assets) owned by you, your spouse, your dependents or jointly owned with someone else. Attach additional pages if necessary).

Checking Accounts	☒ Yes ☐ No	Funeral Plans/Prepaid Burial Item	☐ Yes ☒ No
Savings Accounts	☐ Yes ☒ No	Burial Plots or Contracts	☐ Yes ☒ No
Government Bonds	☐ Yes ☒ No	Stocks and Bonds	☐ Yes ☒ No
Trust Funds	☐ Yes ☒ No	Other (IRA, CD, etc.)	☐ Yes ☒ No
Real Property/Homeplace Property?	☐ Yes ☒ No		

Have you or your spouse given away any assets for less than its value? ☐ Yes ☒ No
If you answered **yes** to any of these questions, please describe below.

Household Member Name with Resource	Type of Resource	Account/Policy Number	Value	Name of Bank, Insurance Company, etc.
KARDARIUS GASS	CHECKING			BANK OF AMERICA

Do you or your spouse own a vehicle? ☐ Yes ☒ No
If **yes**, please describe below.

Household Member Who Owns Vehicle	Vehicle Make	Model	Year	Amount Owed

Do you or your spouse have a life insurance policy? ☐ Yes ☒ No
If **yes**, please complete the following information.

Policy Owner	Insurance Company	Policy Number	Face Value	Cash Value

Tell Us about the Applicant and All Household Members Expenses (Optional for Medicaid applicants)

Do you pay for the care of a dependent child or a disabled adult household member? ☐ Yes ☒ No
If **yes**, complete the chart below.

Person who requires care	Person who pays for care	Reason for care	Provider's Name/Number	Amount paid to Provider	How often paid

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PeachCare for Kids

Application for Benefits

Do you pay transportation expenses for a dependent child or disabled adult household member? ☐ Yes ☒ No
Are these expenses included in the dependent care expenses? ☐ Yes ☐ No
If **no**, please answer this question: **Total miles driven weekly**: _____

Does anyone in the household pay child support to someone living outside of the home? ☐ Yes ☒ No
If **yes**, complete the chart below.

Household Member Obligated to Pay	Name of Child for Whom Support is paid	Obligated Amount to Pay	Actual Amount Paid	To Whom is Child Support Paid?

Tell Us More about the Applicant and All Household Members Expenses (Optional for Medicaid applicants)

Does anyone 60 years of age or older or disabled have medical expenses? ☐ Yes ☒ No
If **yes**, complete the chart below.

Household Member Who Has Expense	Type of Expense (doctor visits, hospital visit, prescriptions, Medicare or health Insurance premiums, glasses)	Amount Owed	Still Owed? Yes/No	Date Paid	Will Insurance Pay? Yes/No

Does anyone 60 years of age or older or disabled have medical expenses for transportation? ☐ Yes ☒ No
If **yes**, complete chart below.

Purpose of the trip (doctor or hospital visit; pharmacy pick-up)	Total miles driven:	Cost of taxi, bus, parking or lodging:

Do you or any household member have shelter and utility expenses? ☐ Yes ☐ No
If **yes**, complete the chart below.

Expense	Amount	How Often?	Who paid?
Rent/Mortgage	500	MONTHLY	KARDARIUS GLASS
Property Taxes			
Property Insurance			
Electricity			
Gas	60	MONTHLY	KARDARIUS GLASS
Garbage			
Telephone	0		
Other			





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Application for Benefits

Do you share monthly household expenses with anyone in the home? ☐ Yes ☒ No
If **yes**, who? _____
Comments/Documentation_____
Paid to whom_____Amount paid $_____per _____
Landlord's Name _____
Landlord's address: _____
_____

Does someone else pay any of these household bills for you? ☐ Yes ☒ No **If yes, complete the chart below:**

Who pays the bill?	What bills are paid?
What amount is paid?	To whom does this person pay the bills?

Please complete the following information if applying for Medicaid.

Tax Filer Information

1. Does anyone in the household plan to file a federal income tax return NEXT YEAR? ☐ Yes ☒ No
   If **yes**, who? (list each person who plans to file)_____
2. Will any of the tax filers listed file jointly with a spouse? ☐ Yes ☒ No If **yes**, please list spouse's name:
   _____
3. Will any of the tax filers claim any dependents on their tax return? ☐ Yes ☒ No If **yes**, please list name(s) of dependents
   _____
4. Will anyone be claimed as a dependent on someone else's tax return? ☐ Yes ☒ No If **yes**, please list the name of the tax filer and the dependent:
   (Filer) _____
   (Dependent) _____
   How is the tax dependent related to the tax filer? _____

Deductions: Check all that apply and give the amount and how often you pay it.

☐ Alimony paid $_____ How often? _____ ☐ Student loan interest $_____ How often? _____
☐ Health Insurance Premiums, 401K, and Other Pre-Tax Deductions $_____ How often? _____
☐ Other deductions $_____ How often? _____ Type: _____

Other health coverage

1. Does anyone have other health insurance that covers anyone in your household? ☐ Yes ☒ No
   If you answered **yes** to question 4 above, please complete the following information and Attachment A:

Name of Policy holder	Health Insurance Company Name, Address and Telephone Number	Type of Coverage (Hospital, Medicare Supplement, Drugs, Major Medical)	Name of Persons Covered	Effective Date	Policy Number

2. Is anyone listed on this application offered health coverage from a job? Check **yes** even if the coverage is from someone else's job, such as a parent or spouse.
   ☒ Yes ☐ No If **yes**, you need to complete Attachment A.
   Is this a state employee benefit plan? ☐ Yes ☒ No

Division of Family and Children Services

Application for Benefits

PeachCare for Kids

3. Have you or anyone listed on this application lost any health coverage in the last 2 months?
   a. ☐ Yes If **yes**, why was it lost? _____
   b. ☒ No
4. Was anyone in Foster Care at age 18 applying for Medicaid? ☐ Yes ☒ No
5. Is anyone in your household American or Alaska Native? ☐ Yes ☒ No
   If **yes**, complete Attachment B.

If anyone is aged (65 or older), blind or disabled (permanent impairment that prevents you from working), please answer questions. (Optional)

1. Is anyone applying for health coverage blind or disabled?
   ☐ Yes ☒ No If **yes**, please list name _____
2. Are you or your spouse currently covered by Medicare?
   ☐ Yes ☒ No If **yes,** please list name _____
3. Are you applying for Medicaid to cover unpaid medical bills from the three months prior to a Supplemental Security Income (SSI) application?
   ☐ Yes ☒ No If **yes**, date of SSI application: _____
4. Are you applying for someone who is now deceased and has unpaid medical bills within the last three (3) months?
   ☐ Yes ☒ No
5. Are you applying for Medicaid to help pay for the care of a person who is in a nursing home?
   ☐ Yes ☒ No
6. Are you applying for Medicaid for a person over the age of 18 whose SSI check has stopped?
   ☐ Yes ☒ No
7. Are you applying for Medicaid to help pay for community-based waiver services such as Community Care Services, NOW/COMP, Hospice Care, Independent Care Waiver, or the Deeming Waiver (Katie Beckett)?
   ☐ Yes ☒ No

Division of Family and Children Services

Application for Benefits

Food Stamp (SNAP) Program Penalties

You may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- Do not give false information or hide information to get benefits that your household should not get.
- Do not use Food Stamps (SNAP) or EBT cards that are not yours and do not let someone else use yours.
- Do not use Food Stamp (SNAP) benefits to buy nonfood items such as alcohol or cigarettes or to pay on credit cards.
- Do not trade or sell Food Stamps (SNAP) or EBT cards for illegal items; such as firearms, ammunition, or controlled substance (illegal drugs).

Any household member who breaks any of the Food Stamp (SNAP) rules on purpose can be barred from the Food Stamp (SNAP) Program for one year to permanently, fined up to $250,000, imprisoned up to 20 years or both. She/he may also be subject to prosecution under other applicable Federal and State laws. She/he may also be barred from the Food Stamp (SNAP) Program for an additional 18 months if court ordered.

Any household member who intentionally breaks the rules may not get Food Stamps (SNAP) for one year for the first offense, two years for the second offense, and permanently for the third offense.

If a court of law finds you or any household member guilty of using or receiving Food Stamp (SNAP) benefits in a transaction involving the sale of a controlled substance, you or that household member will not be eligible for benefits for two years for the first offense, and permanently for the second offense.

If a court of law finds you or any household member guilty of having used or received benefits in a transaction involving the sale of firearms, ammunition, or explosives, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.

If a court of law finds you or any household member guilty of having trafficked benefits for an aggregate amount of $500 or more, you or that household member will be permanently ineligible to participate in the Food Stamp (SNAP) Program upon the first offense of this violation.

If you or any household member is found to have given a fraudulent statement or representation with respect to identity (who they are) or place of residence (where they live) in order to receive multiple Food Stamp (SNAP) benefits, you or that household member will be ineligible to participate in the Food Stamp (SNAP) Program for a period of 10 years.

TANF Program Penalties

In the TANF Program, an IPV (Intentional Program Violation) is an intentional action by an individual to establish or maintain an assistance unit's (AU's) eligibility, or to increase or prevent a decrease in the AU's benefits, by providing false or misleading information or withholding information.

- Any household member who hides information and does not report changes on time or does not tell the truth will lose TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation. The misuse of the cash assistance funds or TANF DEBIT card to withdraw cash or perform transactions at casinos, liquor stores, adult-oriented entertainment facilities "strip clubs", poker rooms, bail bonds, night clubs/salons/taverns, bingo halls, race tracks, gaming establishments, gun/ammunition stores, cruise ships, psychic readers, smoking shops, tattoo/piercing shops, and spa/massage salons is strictly prohibited and will result in a loss of TANF benefits for six months for the first violation, twelve months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member hiding information or you do not report changes on time or do not tell the truth and are convicted, you may not get TANF for 6 months for the first violation, 12 months for the second violation and permanently for the third violation.
- If a court of law finds you or any household member guilty of giving false information about where you live so you can receive benefits in more than one state, you will be barred for 10 years.
- If a court convicted you of a drug-related charge, controlled substance, or a serious violent felony on or after 1/1/1997, you or that household member will not be eligible and/or permanently disqualified.

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Application for Benefits

PeachCare for Kids

For All Food Stamp (SNAP), TANF, and Medicaid Applicants:

I declare under penalty of perjury to the best of my knowledge and belief that the person(s) for whom I am applying for benefits is/are U.S. citizen(s) or are noncitizen(s) lawfully present in the United States. I further certify that all of the information provided on this application is true and correct to the best of my knowledge. I understand and agree that DHS-DFCS, DCH and authorized Federal Agencies may verify the information I give on this application. Information may be obtained from past or present employers. I understand that my information will be used to track wage information and my participation in work activities.

I will report any change in my situation according to Food Stamp (SNAP) and/or TANF program requirements. I will also report if anyone in my household receives lottery or gambling winnings, gross amount of $4250 or more (before taxes or other amounts are withheld). I will report these winnings within 10 days from the end of the month in which my household receives the winnings. I understand if any information is incorrect, my benefits may be reduced or denied, and I may be subject to criminal prosecution or disqualified from DHS-DFCS programs for knowingly providing incorrect information. I understand that I can be prosecuted if I provide false information or hide information. I understand that if I fail to tell DHS-DFCS about some of my expenses during my application or renewal process and/or fail to verify them, DHS-DFCS will not budget that expense in calculating the amount of my SNAP benefits.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agr that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

KARDARIN GLASS
Applicant's Signature

3/7/23
Date

Authorized Representative's Signature

Date

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

_____Yes

_____No

_____I do not want to answer the Voter Registration question

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at 2 Martin Luther King Jr. Drive, Ste. 802, West Tower, Atlanta, GA 30334 or by calling (404) 656-2871.

IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application.

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF, and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (877) 423-4746 or the DCH Katie Beckett (KB) Team at (678) 248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form from the KB Team or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

You can ask your case worker for a copy of the DFCS Civil Rights, ADA/Section 504 complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at https://dch.georgia.gov/adasection-504-and-civil-rights.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or religion.

Do Not Send Applications to the USDA or HHS

Nondiscrimination Statement

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:** Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **phone:** (833) 620-1071; or
4. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746.

Do Not Send Applications to the USDA or HHS

Division of Family and Children Services

Rights and Responsibilities

Welcome to the Georgia Division of Family and Children Services!

If you need help reading or completing this document or need help communicating with us, ask us or call (877) 423-4746. Our services, including interpreters, are free. If you are deaf, hard-of-hearing, deaf-blind or have difficulty speaking, you can call us at the number above by dialing 711 (Georgia Relay).

Community Outreach Services
For more information about other DHS services, please visit our website at http://dfcs.georgia.gov or call (877) 423-4746.

We are giving you this information to help you understand your rights and responsibilities when you receive help for Food Assistance, Cash Assistance and Medical Assistance. Please read over the Rights and Responsibilities for the programs in which you are applying and sign the signature page. If you are applying for someone else, these rights and responsibilities apply to that person as well.

The Georgia Department of Human Services ("DHS") collects Personally Identifiable Information (PII), such as names, addresses, telephone numbers, email addresses, and dates of birth, etc., during your application for benefits. By submitting any personal information to us, you agree that we may collect, use, and disclose any such personal information in accordance with DHS policies, procedures, and as permitted or required by law and/or regulations.

What Are My Rights in the Food Stamp (SNAP), TANF and Medicaid Programs?

In all programs, you have the right to:

- **request assistance filling out this form and free language assistance services** (interpreters, translated materials, or direct in-language services) if you have trouble reading, writing, speaking, or understanding the English language.
- **request auxiliary aids and services and reasonable modifications** if you or someone in your household has a disability.
- **request a fair hearing in writing or in person**. You have the right to be represented by a household member, legal counsel, a relative, a friend or other spokesperson.
  If you are not satisfied with the action we have taken on your case, you can request a hearing by contacting the county office where you applied for benefits, by calling (877) 423-4746, or uploading a written request at www.gateway.ga.gov.
- **review some of the material and information in your case file**. However, you may not be able to see all of the information in the case file, such as names of people who have given us information about you or your household members or information about any criminal prosecutions involving you or any of your household members.
- **decide if you want to provide Social Security Number (SSN), citizenship, or immigration status information.** To qualify for public assistance, individuals must be a U.S. citizen, U.S. National, or eligible immigrant. Pursuant to the Food and Nutrition Act of 2008, 7 U.S.C. § 2011-2036, 7. C.F.R. § 273.2, 45 C.F.R. § 205.52, 42 C.F.R. § 435.910, and 42 C.F.R. § 435.920, DFCS is authorized to request your and your household members SSN.

  Individuals who are applying for public assistance must provide or apply for an SSN, and/or verify their citizenship or immigration status, if we are unable to verify through electronic data sources. Some immigrants are eligible, and some are not, depending on their legal status. For Medicaid, depending on their immigration status, some immigrants may be eligible for full Medicaid benefits or Emergency Medical Assistance (EMA) benefits. If you or anyone in your household does not have an SSN, we can help you

apply for one.

Applying for an SSN will not delay a decision on your application for benefits. If you are applying for emergency medical services only, you do not have to provide your SSN or information about your immigration status. EMA, including labor and delivery, is available for pregnant non-qualified and undocumented immigrants.

An individual, who is not applying for public assistance and who does not provide an SSN, citizenship or immigrant status may be designated as a non-applicant. A non-applicant is not required to provide an SSN, citizenship, or immigrant status but is required to provide other information that may affect the eligibility of other applicant household members such as income or resources.

A non-applicant is not eligible to receive benefits.

Only the people who give information to us about their SSN, citizenship, or immigration status will be eligible to receive benefits. We will use this information to check the Income and Eligibility Verification System (IEVS). We will also match your information with other Federal, state, and local agencies to verify your income and eligibility, wage information and work activities. This information may also be given to law enforcement officials to use to catch people who are running from the law. If your household has a Food Stamp (SNAP) claim, the information on this application, including SSNs, may be given to Federal and State agencies and private claims collection agencies for them to use in collecting the claim.

We will not share your information with the United States Citizenship and Immigration Services (USCIS); however, if immigration status information has been submitted on your application, this information may be subject to verification through USCIS and may affect your household's eligibility and benefit level.

We will not deny benefits to applicant household members because other household members fail to provide their SSN, citizenship, or immigration status. Applying for or receiving **Food Stamp (SNAP) benefits does not** make a non-citizen a public charge.

Receiving or accepting **Supplemental Security Income (SSI), TANF cash assistance, Institutionalized Long-Term Care Medicaid, or state General Assistance could make** a non-citizen a public charge if all eligibility criteria are met. However, receiving these benefits does not automatically make an individual inadmissible or ineligible to adjust his/her status to lawful permanent resident on a public charge basis. A "public charge" means you are a person who is likely to become "primarily dependent" on the government to maintain your way of life, as demonstrated by either the receipt of public cash assistance for income maintenance or by institutionalization for long-term care at the government's expense."

If you are considered to be a public charge, you will not be deported, or denied permanent status because you have applied for or receive public assistance.

- **decide if you want to provide information about your race and ethnicity**. We collect data on race and ethnicity to ensure we are in compliance with Federal civil rights laws. By providing this information, you will assist us in administering our programs in a non-discriminatory manner. Your household is not required to give us this information and it will not affect your eligibility or benefit level.

What Are My Responsibilities in the Food Stamp (SNAP), TANF and Medicaid Programs?

In all programs, you are responsible for:

- giving your worker correct information and providing proof of statements needed to receive benefits. When you sign this form, you are giving your worker permission to get information from your employer, bank, neighbor, or others so we can make sure you are receiving the correct amount of benefits.

Division of Family and Children Services

Rights and Responsibilities

- telling the truth at all times. If you or someone who is applying for you provides incorrect information, you may lose your benefits or be subject to criminal prosecution for knowingly providing false information.

- providing proof that you or anyone in your household applying for benefits is a U.S. Citizen, U.S. National or qualified immigrant. **Note:** Your worker will give you a list of ways you can prove your citizenship or immigration status if they are unable to verify through electronic data sources. For Medicaid, if you are not a U.S. Citizen, U.S. National or qualified immigrant, you may qualify for emergency coverage, and an individual without qualifying status will not be required to provide proof of status.

- reporting certain changes in your household situation. Each program has different reporting requirements. See the responsibilities section for each program for things you need to report.

What Other Responsibilities Do I Have in the Food Stamp (SNAP) Program?

In the Food Stamp (SNAP) Program, you are also responsible for:

- cooperating with Quality Control reviewers when they call or come to your home to interview you about the information you have given your case manager. If you do not cooperate with them, your case may be denied or closed.

- repaying benefits you should not have received.

- reporting when your household's total gross monthly income is more than 130% of the Federal Poverty Level for the household size. If you are a working adult with no children, you must report when your work hours fall below 20 hours per week or 80 hours per month. You must report these changes within 10 days from the end of the month in which the increase or change occurred. You may be given a Notice of Simplified Reporting Requirements, which explains more about this requirement.

- reporting when your household receives substantial lottery and gambling winnings. This is a cash prize won in a single game. If you or a household member receives lottery or gambling winnings, gross amount of $4250 or more (before taxes or other amounts are withheld), you must report these winnings within 10 days from the end of the month in which the household member received the winnings.

Food Stamp (SNAP) households **CAN NOT** use their benefits to purchase non-food items such as beer, wine, liquor, cigarettes, tobacco, pet foods, soaps, paper products and household supplies.

Food Stamp (SNAP) households also **ARE NOT** allowed to purchase food on credit with their benefits.

Food Stamp (SNAP) households **CAN NOT** give false information or hide information to get benefits that their household should not get.

Food Stamp (SNAP) households **CAN NOT** use Food Stamps (SNAP) or EBT cards that are not theirs and should not let someone else use their card.

Food Stamp (SNAP) households **CAN NOT** trade or sell Food Stamps (SNAP) or EBT cards for illegal items such as firearms, ammunition, or a controlled substance (illegal drugs).

What Are My Rights and Responsibilities for Reporting Household Expenses in the Food Stamp (SNAP) Program?

In the Food Stamp (SNAP) Program, certain household expenses such as shelter costs, medical bills, dependent care costs, and child support paid outside the home may affect the amount of benefits you receive.

If you have heating or cooling expenses, you may be eligible to receive the standard utility allowance.

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If you have only one utility expense and it is NOT a heating or cooling expense, you may be eligible to receive a deduction for the actual expense incurred.

If you have only one telephone expense and no heating or cooling expenses, you may be eligible to receive the standard telephone allowance. If you want us to consider these expenses, you are responsible for reporting and verifying them. If you fail to report or verify actual utility expenses, we will not use them to determine your benefit amount.

What Are the Penalties in the Food Stamp (SNAP) Program?

The Food Stamp (SNAP) Program penalties are provided in the chart below.

Intentional Program Violations	
If you or any household member... ▪ hides information or does not tell the truth; ▪ uses EBT cards that belong to someone else; ▪ uses FS benefits to buy alcohol or tobacco, trades or sells FS benefits or EBT cards	You will be INELIGIBLE ▪ for **12 months** for the first offense, ▪ **24 months** for the second offense, ▪ and **permanently** for the third offense.
▪ has used or received FS benefits in a transaction involving the sale of a controlled substance	▪ for **24 months** for the first offense and ▪ **permanently** for the second offense.
▪ has used or received FS benefits in a transaction involving the sale of firearms, ammunition, or explosives after 8/22/1996	▪ **permanently** for the first offense.
▪ has been convicted for trafficking benefits for an amount of $500 or more after 8/22/1996	▪ **permanently** for the first offense.
▪ has a felony conviction because of behavior related to the possession, use or distribution of a controlled substance (drugs) after 8/22/1996	▪ until you are in compliance with the terms of probation or parole. ▪ until you complete all the terms of probation or parole.
▪ has a felony conviction as an adult for aggravated sexual abuse, murder, sexual exploitation, and other abuse of children, a Federal or State offense involving sexual assault, or an offense under State law determined by the Attorney General to be substantially similar to such an offense after 2/7/2014	▪ until you are in compliance with the terms of probation or parole. ▪ until you complete all the terms of probation or parole.
▪ is fleeing to avoid prosecution, custody, or confinement for a felony	▪ until you are no longer fleeing.
▪ is violating a condition of your probation or parole	▪ until you are no longer a probation or parole violator.
▪ has given false information about where you live or about your identity (who you are) to get multiple FS benefits in more than one area after 8/22/1996	▪ for **10 years.**

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What Other Rights Do I Have in the TANF Program?

In the TANF Program, you have a right to:

- be excused from certain rules if you are a victim of domestic violence, sexual harassment, sexual assault, or stalking. Your case manager will talk to you about the rules that you will not have to follow.

What Other Responsibilities Do I Have in the TANF Program?

In the TANF Program, you are responsible for:

- cooperating with state and federal personnel who work for Fraud Prevention or the Office of Investigative Services and who are doing special case reviews. If you do not cooperate, your case may be denied or closed.
- repaying benefits you should not have received.
- participating in a work activity if you are a parent or an adult included in the TANF benefit, unless you are exempt. We will work with you to find the best work activities to help you become self-sufficient. We may have to reduce or stop your TANF benefits if you do not cooperate with us, and there is not a good reason.
- reporting that you or someone included in your TANF benefit has received or is expecting to receive a lump sum of money. Your TANF benefits may stop for one or more months, and your family may have to live on the lump sum for several months.
- cooperating with the Division of Child Support Services if you receive TANF benefits. You must help the Division of Child Support Services determine who is the father(s) of your child/children and help them get a court order for child support. If you do not cooperate with them and there is not a good reason, your TANF benefits may stop.
- notifying your case manager if you want to receive child support money instead of your TANF benefits. When you get TANF benefits, you may not receive all of your child support payment. You may receive only a portion of it called a "gap" payment. The state keeps the rest of the child support payment to pay back the TANF benefits that you receive.
- reporting certain changes in your household situation about you and other eligible household members within 10 days of knowing about them. Please let us know if you or any member of your household:
  - starts or stops receiving any unearned income
  - changes jobs, gets a new job, quits a job, or gets laid off
  - moves in or out of your home
  - has a baby or there is any other change
  - a child drops out of school
  - a child is absent from the home for a period of 45 consecutive days or longer
  - the whole family moves to another county or state, or,
  - someone dies

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What Are the Penalties in the TANF Program?

In the TANF Program, there are penalties:

If you ...	You will lose TANF benefits ...
• hide information, do not report changes on time or do not tell the truth	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• hide information, do not report changes on time or do not tell the truth and are convicted in a court of law	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• give false information about where you live so you can receive benefits in more than one state and are convicted on or after 1/1/1997	• for 10 years.
• are convicted of other IPVs committed on or after 7/1/1998	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• Individuals convicted of an IPV for using cash assistance funds or the TANF EBT transactions performed at prohibited places on or after 6/1/2012	• for 6 months for the first violation; • for 12 months for the second violation; • permanently for the third violation.
• are convicted of a serious violent felony or a felony related to possession, use or distribution of a controlled substance on or after 1/1/1997	• permanently
• are fleeing to avoid prosecution, custody, or confinement for a felony	• and will be penalized until no longer fleeing to avoid prosecution, custody, or confinement
• are violating a condition of probation or parole	• and will be penalized until no longer a probation/parole violator

Division of Family and Children Services

Rights and Responsibilities

PeachCare for Kids®

What Other Rights Do I Have in the Medicaid Program?

In the Medicaid Program, you have a right to:

- receive Medicaid even if you have other health insurance.
- choose your Medicaid doctor or provider. Always ask your doctors if they accept Medicaid as payment for their services.
- have your Medicaid application approved or denied within 10, 45 or 60 days from the date you apply, depending on the type of Medicaid.
- be excused from providing information about your children's absent parent or from pursuing medical support from the absent parent if you have a good reason such as domestic violence. Talk to your case manager if you think you have a good reason.

What Other Responsibilities Do I Have in the Medicaid Program?

In the Medicaid Program, you are also responsible for:

- telling your worker if you or your children have other health insurance. If the health insurance changes or ends, you must tell your worker within 10 days. The health insurance information is sent to the Department of Community Health. In most cases, your other health insurance must pay your medical expenses first. You must tell your doctor or other health care providers that you have other insurance so that they can bill the other health insurance providers before they bill Medicaid.
- cooperating with the Medicaid Estate Recovery Program if you are:
  - a resident in a nursing home
  - a resident in an intermediate care facility for individuals with intellectual disabilities
  - a resident in another medical institution where medical care is paid by Medicaid
- cooperating with the Medicaid Estate Recovery Program if you are age 55 years or older and:
  - receive home and community-based services.
  - are enrolled in and receive services through a waiver program.
- I agree to assign to the State all rights to medical support and to payment for medical care from any third party (hospital and medical benefits). I agree to cooperate with the State in identifying and providing information to assist the State in pursuing any third party who may be liable to pay for care and services. I understand that I must report any payments received for medical care within ten days. (If you are completing this form on behalf of another individual and do not have the power to execute an assignment for that individual, the individual will need to execute an assignment of the rights described above as a condition of his/her eligibility for Medicaid).
- reporting changes about you and the other people in your Medicaid case. Please report:
  - if you or other household members move
  - if you or other household members change jobs, get a new job, quit a job, or get laid off.
  - if you or other household members have a change in income or resources
  - if a family member moves in or out of your home
  - if you or another household member inherits or receives money or property from any source
  - if someone in your home dies or gets married
  - any other changes

- telling your case manager when your pregnancy ends. Pregnancy ends with the birth of the baby, a miscarriage, or an abortion. You must report the end of the pregnancy within 10 days.
- I agree to give the State the right to require an absent parent to provide medical insurance, if available. I understand I must get medical support from the absent parent if it is available and must cooperate with the Division of Child Support Services in obtaining this support. If I do **not** cooperate, I understand I may lose my Medicaid benefits and only my children will receive benefits unless good cause is established.
- cooperating with Medicaid Eligibility Quality Control when they call or come to your home to interview you about the information you have given your case manager.

Committing fraud or abuse is against the law. You may be referred to the Medicaid and PeachCare for Kids® Program Integrity Unit. Violators may be limited to using one provider, terminated from the program, or asked to reimburse the Department of Community Health for medical services provided.

Fraud is a dishonest act done on purpose. Abuse is an act that does not follow good practices.

Examples of participant fraud and abuse are:

- Letting someone else use your Medicaid, PeachCare for Kids® or CMO health insurance card.
- Getting prescriptions with the intent of abusing or selling drugs
- Using forged documents to get services
- Misusing or abusing equipment that is provided by Medicaid or PeachCare for Kids®
- Providing incorrect information or allowing others to do so in order to obtain Medicaid or PeachCare for Kids® eligibility
- Failure to report changes which occur in income, living arrangements, or resources.

To report suspected Medicaid fraud on recipients or providers, call the Georgia Department of Community Health-Office of Inspector General at (local) (404) 463-7590 or (toll free) (800) 533-0686; by email at oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Peachtree Street NW, 5th Floor, Atlanta, GA 30303; or visit https://dch.georgia.gov/report-medicaidpeachcare-kids-fraud.

Division of Family and Children Services

PeachCare for Kids™

Rights and Responsibilities

Signature Page

I have received a copy of Form 297A, Rights and Responsibilities, for Benefits.

I certify, under penalty of perjury, all the information provided and everything I have told is the complete truth, as far as I know.

K. K. G — Signature

3/7/23 — Date

Authorized Representative / Witness / Responsible Person — Date

Division of Family and Children Services

Rights and Responsibilities

Georgia Department of Human Services Division of Family and Children Services
Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services and Third-Party Liability Requirements

Benefits of Child Support Services

Your help in the child support services process may be of value to you and your child because it may result in:

- Finding the absent parent.
- Legally establishing your child's paternity.
- Receipt of child support payments that may give you more money than if you receive Temporary Assistance for Needy Families (TANF).
- Acquisition of private health insurance through the absent parent.
- Acquisition of rights to future Social Security, veterans, or other government benefits.

Cooperation with DFCS and DCSS

The law requires you to help the Division of Family and Children Services (DFCS) and the Division of Child Support Services (DCSS) get any support owed to you and the children for whom TANF is requested, unless you have good cause for not helping.

In helping DFCS or DCSS, you must do one or more of the following:

- Name the absent parent(s) of any child for whom you are requesting TANF or Medicaid.
- Provide information to help find the absent parent(s).
- Help determine who the legal father is if your child was born out of wedlock.
- Agree to have a blood test if the person you name as the father denies paternity.
- Help the state get money owed to you and/or the child who receives TANF.
- Provide information about medical insurance the absent parent has on your child.

You must come to the DFCS office, DCSS or court to sign papers or provide needed information.

Good Cause

You may have good cause for not wanting to help DCSS collect child support or medical coverage for your child. You may not have to help if you believe helping is not in your child's best interest, and if you can prove it. If you want to claim good cause, you must tell your worker. You can do this at any time.

If You Do Not Help and Do Not Have Good Cause

- You will not be eligible to receive TANF for yourself and your child.
- Your child may still be eligible for Medicaid.

Good Cause Reasons

You may claim good cause for any of the following reasons:

- Your help may cause serious physical or emotional harm to your child or to you.
- The child was born as a result of rape or incest.
- Court proceedings are underway for adoption of the child.
- An agency is helping you to decide whether to place the child for adoption.

To Prove Good Cause, You Must

- give DFCS information it needs to decide if you have good cause for not helping. If you fear physical harm and cannot get proof, DFCS may still be able to make a good cause determination.
- give proof to DFCS within 20 days of claiming good cause. DFCS will give you more time only if you have trouble getting proof.

DFCS may excuse you from helping based on the information you provide. Or DFCS may ask you to provide more information. DFCS will not contact the absent parent without telling you.

NOTE: If you are applying for TANF, you will not be approved until you give DFCS proof of your claim of good cause or the information DFCS needs to investigate your claim.

Division of Family and Children Services

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PeachCare for Kids®

EXAMPLES OF PROOF OF GOOD CAUSE

- birth certificate, medical or law enforcement records showing that the child was born as a result of rape or incest
- court or other legal documents showing that adoption proceedings have begun
- court, medical, criminal, child protective services, social services, psychological or law enforcement records showing that the absent parent may hurt you or the child
- medical records or written statements from a mental health professional showing the history and current status of your and/or the child's emotional health
- a written statement from a public or private agency showing you are being helped to decide whether to give your child up for adoption
- sworn statements from friends, neighbors, clergy, social workers, or medical professionals who know why you have good cause.

If you need help in getting any of the documents, ask your worker.

Child Support Rules

If you receive TANF, you give the state of Georgia, by law, any rights you have to receive child support. Once the court order is established, the absent parent will be required to pay child support through DCSS. After the court order is established, you will be required to report any money you receive directly from the absent parent. You must also help establish paternity for your child and cooperate with DCSS in establishing a child support order. If you do not cooperate and do not have good cause, you may not be eligible for TANF.

If you receive TANF and the absent parent pays child support through the Division of Child Support Services (DCSS), you probably will NOT receive the full amount of the child support payment. Instead, you may receive a "gap" payment. All child support paid by an absent parent, which is in excess of the "gap" amount, is retained by DCSS and is used to pay back the TANF funds that you have received. ***Your TANF case manager can explain gap budgeting and the payment procedures to you.***

If your TANF case is closed, child support payments will be sent to you up to the amount of the absent parent's current monthly obligation. Any child support amount paid over the current obligation will be kept by the state to repay past TANF grants received by you. Once the past TANF grants are repaid, you will be sent all child support paid by the absent parent.

If your TANF case is closed and *then reopened, any child support back payments due you will be assigned to the state up to the* amount of all TANF money you have ever received. When the Unreimbursed Public Assistance (UPA) is repaid, then you will start receiving any back payments owed to you.

If you receive child support payments to which you are not entitled, you may have to repay the state. The state will notify you of the amount of the overpayment and the timeframe for repayment.
DCSS may review the DFCS good cause decision in your case. If you request a hearing about the decision, DCSS may participate in the hearing.

If you have good cause for not helping, DCSS will not try to establish paternity or collect child support.

I have read this notice about my rights to claim good cause and not helping to establish paternity or to collect child support from the absent parent.

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Domestic Violence can happen to ANYONE.

- Domestic violence occurs on all social and economic levels, regardless of employment or education, race, or ethnic background, religion, marital status, physical ability, age, or sexual orientation.
- Each year more than 50,000 incidents of domestic violence are reported to Georgia Law Enforcement agencies.
- More than 50 percent of all women are battered by intimate partners at some time in their lives.
- A woman is physically abused every 9 seconds in this country, an estimated 2 to 4 million women annually.
- Battering is the leading cause of injury to women in the United States, more than rape, mugging or auto accidents combined.
- Nationally, 50 percent of all homeless women and children are on the streets because of violence in the home.
- Between 15 and 25 percent of pregnant women are battered.
- The Federal Bureau of Investigations (F.B.I). estimates that only 1 in 10 incidents of domestic violence are ever reported.
- Every day, 4 women in the United States, are murdered by their intimate partner.

FOR MORE INFORMATION

Free, confidential services are available from domestic violence shelter and programs supported by the Department of Human Services.

FOR HELP 24 HOURS A DAY, CALL (800) 334-2836

Call this toll-free number to speak to someone at your local domestic violence shelter. You can call from anywhere in the state to find a safe place to stay for you and your children and get other resources to help you.

What is Domestic Violence, Sexual Harassment, Sexual Assault, or Stalking?

- **Domestic violence** can include being hit, kicked, beaten, raped, choked, threatened, controlled, or kept from getting what you need to live (such as food, medicine, or a home) by a spouse, boyfriend, partner, or "ex."
- **Sexual harassment** is hostile, intimidating, or oppressive behavior based on sex that creates an offensive work environment.
- **Sexual assault** is nonconsensual sexual act proscribed by Federal, Tribal, or State law, including when the victim lacks capacity to consent.
- **Stalking** is the act or crime of willfully and repeatedly following or harassing another person in circumstances that would cause a reasonable person to fear injury or death especially because of express or implied threats.

Your local Department of Family and Children Services wants to help you and your children stay safe.

If any of these things are happening to you, talk to your caseworker.

- Has your spouse, partner, boyfriend, or "ex" ever hit or slapped you?
- Has this person ever threatened to harm you?
- Has this person threatened to take your children?
- Does the person insult you or act jealous?
- Do you ever feel this person is running your life or keeping you away from your family and friends, or preventing you from going to work or school?
- Does the person keep track of what you do, where you go or who you talk to on the phone?
- Does the person destroy things you own or care about?
- Are you afraid of this person?
- Is it unsafe for you to go home?

If you answered YES to any of the questions, it may be time to think about safety for you and your children.

Domestic Violence and TANF

- Some of the requirements of Temporary Assistance for Needy Families (TANF) may not apply to you.
- You can tell a DFCS caseworker **anytime** that your partner is being violent.
- DFCS will refer you to someone you can talk to about your situation.
- DFCS will help you with assistance, a safe place to stay for you and your children, medical and mental health care, treatment for addiction and special help for victims of crime and domestic violence.
- DFCS will not share the information with anyone outside the agency without your knowledge.
- Let DFCS know when you are no longer in a dangerous situation.

Division of Family and Children Services

Rights and Responsibilities

Notice of ADA/Section 504 Rights

Help for People with Disabilities

The Georgia Department of Human Services and the Georgia Department of Community Health ("the Departments") are required by federal law* to provide persons with disabilities an equal opportunity to participate in and qualify for the Departments' programs, services, or activities. This includes programs such as SNAP, TANF, and Medical Assistance.

The Departments provide reasonable modifications when the modifications are necessary to avoid discrimination based on disability. For example, we may change policies, practices, or procedures to provide equal access. To ensure equally effective communication, we provide persons with disabilities or their companions with disabilities communication assistance, such as sign language interpreters. Our help is free. The Departments are not required to make any modification that would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.

How to Request a Reasonable Modification or Communication Assistance

Please contact your caseworker if you have a disability and need a reasonable modification, communication assistance, or extra help. For instance, call if you need an aid or service for effective communication, like a sign language interpreter. You may contact your caseworker or call DFCS at (877) 423-4746 or the DCH Katie Beckett (KB) Team at (678) 248-7449 to make your request. You may also make your request using the DFCS ADA Reasonable Modification Request Form, which is available at your local DFCS office or online at https://dfcs.georgia.gov/adasection-504-and-civil-rights, or you may obtain the DCH ADA Reasonable Modification Request Form from the KB Team or online at https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett, but you do not have to use a form.

How to File a Complaint

You have the right to make a complaint if the Departments have discriminated against you because of your disability. For example, you may file a discrimination complaint if you have asked for a reasonable modification or sign language interpreter that has been denied or not acted on within a reasonable time. You can make a complaint orally or in writing by contacting your case worker, your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For DCH, contact the KB Team ADA/Section 504 Coordinator at 2211 Beaver Ruin Road, Ste. 150, Norcross, GA 30071, or PO Box 172, Norcross, GA 30091, (678) 248-7449. The DCH email is: dch.adarequests@dch.ga.gov.

You can ask your case worker for a copy of the DFCS Civil Rights, ADA/Section 504 complaint form. The complaint form is also available at https://dfcs.georgia.gov/adasection-504-and-civil-rights. If you need help making a discrimination complaint, you may contact the DFCS staff listed above. Individuals who are deaf or hard of hearing or who may have speech disabilities may call 711 for an operator to connect with us. The email for DCH Civil Rights complaints is: dch.civilrights@dch.ga.gov. The link for the DCH Civil Rights process and complaint form is located at https://dch.georgia.gov/adasection-504-and-civil-rights.

You may also file a discrimination complaint with the appropriate federal agency. Contact information for the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) is within the "Nondiscrimination Statement" included within.

**Section 504 of the Rehabilitation Act of 1973; Americans with Disabilities Act of 1990; and the Americans with Disabilities Act Amendments Act of 2008 ensure persons with disabilities are free from unlawful discrimination.*

Under the **Department of Community Health (DCH)** policy, the Medical Assistance programs cannot deny you eligibility or benefits based on your race, age, sex, disability, national origin, or religion.

Division of Family and Children Services

Rights and Responsibilities

Do Not Send Applications to the USDA or HHS

Nondiscrimination Statement

In accordance with federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Programs that receive federal financial assistance from the U.S. Department of Health and Human Services (HHS), such as Temporary Assistance for Needy Families (TANF), and programs HHS directly operates are also prohibited from discrimination under federal civil rights laws and HHS regulations.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or who have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

CIVIL RIGHTS COMPLAINTS INVOLVING USDA PROGRAMS

USDA provides federal financial assistance for many food security and hunger reduction programs such as the Supplemental Nutrition Assistance Program (SNAP), the Food Distribution Program on Indian Reservations (FDPIR) and others. To file a program complaint of discrimination, complete the Program Discrimination Complaint Form, (AD-3027) found online at https://www.usda.gov/sites/default/files/documents/USDA-OASCR P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **mail:** Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334, Alexandria, VA 22314; or
2. **fax:** (833) 256-1665 or (202) 690-7442; or
3. **phone:** (833) 620-1071; or
4. **email:** FNSCIVILRIGHTSCOMPLAINTS@usda.gov.

For any other information regarding SNAP issues, persons should either contact the USDA SNAP hotline number at (800) 221-5689, which is also in Spanish, or call the state information/hotline numbers (click the link for a listing of hotline numbers by state); found online at: SNAP hotline.

CIVIL RIGHTS COMPLAINTS INVOLVING HHS PROGRAMS

HHS provides federal financial assistance for many programs to enhance health and well-being, including TANF, Head Start, the Low Income Home Energy Assistance Program (LIHEAP), and others. If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex (including pregnancy, sexual orientation, and gender identity), or religion in programs or activities that HHS directly operates or to which HHS provides federal financial assistance, you may file a complaint with the Office for Civil Rights (OCR) for yourself or for someone else.

To file a complaint of discrimination for yourself or someone else regarding a program receiving federal financial assistance through HHS, complete the form online through OCR's Complaint Portal at https://ocrportal.hhs.gov/ocr/. You may also contact OCR via mail at: Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201; fax: (202) 619-3818; or email: OCRmail@hhs.gov. For faster processing, we encourage you to use the OCR online portal to file complaints rather than filing via mail. Persons who need assistance with filing a civil rights complaint can email OCR at OCRMail@hhs.gov or call OCR toll-free at 1-800-368-1019, TDD 1-800-537-7697. For persons who are deaf, hard of hearing, or have speech difficulties, please dial 7-1-1 to access telecommunications relay services. We also provide alternative formats (such as Braille and large print), auxiliary aids and language assistance services free of charge for filing a complaint.

This institution is an equal opportunity provider.

Under the Department of Human Services (DHS), you may also file other discrimination complaints by contacting your local DFCS office, or the DFCS Civil Rights, ADA/Section 504 Coordinator at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746. For complaints alleging discrimination based on limited English proficiency, contact the DHS Limited English Proficiency and Sensory Impairment Program at 2 Peachtree Street NW, 29th Floor, Atlanta, GA 30303, (877) 423-4746.

Do Not Send Applications to the USDA or HHS

HIPAA Notice of Privacy Practices
Georgia Department of Human Services

Date*: *January 18, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

The Department of Human Services (DHS) is an agency of the Executive Branch of Georgia government charged with the administration of numerous federal programs responsible for the storage, use and maintenance of medical and other confidential information. Federal and state laws establish strict requirements for these programs regarding the use and disclosure of confidential and protected information. DHS is required to comply with those laws as noted throughout this notice.

OBLIGATIONS OF THE DEPARTMENT OF HUMAN SERVICES:

DHS is required by law to:

- Maintain the privacy of your health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice currently in effect.

HOW DHS MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways DHS may use and disclose protected health information that identifies you ("Health Information"). Except for the purposes described below, DHS will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to the Privacy Officer at the contact information below.

For Treatment. DHS may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, DHS may disclose Health Information to doctors, nurses, technicians, or other personnel who are involved in your medical care and need the information to provide you with medical care.

For Payment. DHS may use and disclose Health Information so that DHS or others may bill and receive payment related to your care, an insurance company, or a third party for the treatment and services you received. For example, DHS may provide your health plan information so that treatment may be paid for.

For Health Care Operations. DHS may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that quality care is received and to operate, manage, and administer the functions of the agency. For example, DHS may use and disclose information to make sure the medical care you receive is of the highest

quality. DHS also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. DHS may use and disclose Health Information to contact you to remind you of an appointment with a physician. DHS also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, DHS may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. DHS also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, DHS may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before DHS uses or discloses Health Information for research, the project will go through a special approval process. Even without special approval, DHS may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. DHS will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. DHS may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. DHS may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, DHS may utilize the services of a separate entity to perform information technology services. All DHS business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, DHS may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, DHS may release Health Information as required by military command authorities. DHS also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. DHS may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. DHS may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if it is believed a patient has been the victim of abuse, neglect or domestic violence. DHS will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. DHS may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. DHS may use or disclose your Health Information to provide legally required notices of unauthorized access to or disclosure of your Health Information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, DHS may disclose Health Information in response to a court or administrative order. DHS also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. DHS may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. DHS may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. DHS also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. DHS may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. DHS may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, DHS may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to

provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE DHS TO PROVIDE YOU AN OPPORTUNITY TO OBJECT AND OPT OUT:

Individuals Involved in Your Care or Payment for Your Care. Unless you object, DHS may disclose to a member of your family, a relative, a close friend or any other person you identify, your Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, DHS may disclose such information as necessary if it is determined that it is in your best interest based on the professional judgment of DHS.

Disaster Relief. DHS may disclose your Health Information to disaster relief organizations that seek your Health Information to coordinate your care or notify family and friends of your location or condition in a disaster. DHS will provide you with an opportunity to agree or object to such a disclosure whenever it is practical to do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:

The following uses and disclosures of your Health Information will be made only with your written authorization:

1. Uses and disclosures of Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Health Information.

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to DHS will be made only with your written authorization. If you do provide DHS with an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer. Upon receipt, DHS will no longer disclose Health Information under the authorization. However, disclosures made in reliance upon your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information DHS has about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the below referenced Privacy Officer. DHS has up to 30 days to make your Health Information available to you and DHS may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. DHS may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. DHS may deny your request in certain limited circumstances. If DHS does deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and DHS will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. DHS will make every effort to provide access to your Health Information in the form or format you request if it is readily producible in such form or format. If the Health Information is not readily producible in the form or format you request, your record will be provided in either our standard electronic format. If you do not want this form or format, a readable hard copy form will be provided. DHS may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information DHS has is incorrect or incomplete, you may request DHS to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the below referenced Privacy Officer.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures DHS made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information DHS uses or disclosed for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information DHS discloses to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that DHS not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Privacy Officer. DHS is not required to agree to your request unless you are requesting DHS restrict the use and disclosure of your Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid "out-of-pocket" in full. If DHS agrees, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications. You have the right to request that DHS communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that DHS only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. DHS will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may request a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please contact the Privacy Officer. You may also obtain a copy from the DHS website, on the Office of General Counsel homepage:
https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel

CHANGES TO THIS NOTICE:

DHS reserves the right to change this notice and make the new notice apply to Health Information already obtained as well as any information received in the future. DHS will post a copy of the current notice at our office and on the website at https://dhs.georgia.gov/organization/about/division-offices/office-general-counsel. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you have any questions about this notice, please contact:

Georgia Department of Human Services
Privacy Officer
2 Peachtree Street NW, 29th Floor
Atlanta, GA 30303-3142
HIPAADHS@dhs.ga.gov

If you believe your privacy rights have been violated, you may file a complaint in writing by contacting the above-referenced Privacy Officer. Please include your name, phone number, case number and a description of the complaint. **You will not be penalized for filing a complaint.**

You may also file with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). For more information on HIPAA privacy requirements, HIPAA electronic transactions, and code sets regulations and the proposed HIPAA security rules, please visit U.S. Department of Health and Human Services web site at: https://www.hhs.gov/hipaa/index.html.

If you have questions about your health or your health care services, you should contact your health care provider (physician, pharmacy, hospital or other medical provider).

[SIGNATURE PAGE TO FOLLOW]

Signature Page

If you would like to acknowledge receipt of this DHS HIPAA Notice of Privacy Practices, please sign below, and return this page to the address below.

I have read, understand, and acknowledge receipt of the DHS HIPAA Notice of Privacy Practices.

Kandis K. Glass
Signature

3/7/23
Date

Kandis Kandis Glass
Print Name

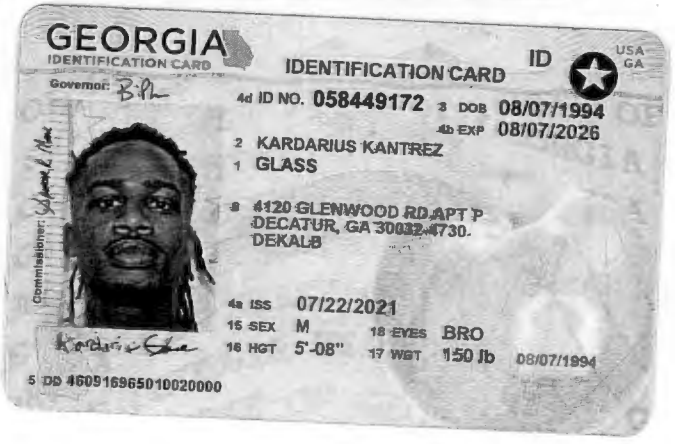
Return Address:

[Insert Local Address here]

Notice of Fileing

If it's not one thing its Another. I was Just in that long foodStamp line people yelling and Crushing. The Securty guard don't treat us Right. The System is not working they told me to do A Renewl form. I did. I waited with Patience. not they said I heed to Apply. I have money on my Card and I don't know why they think I am playing about any food-stamps. Everybody in line at Banxhead DFCS was So MADD. At the poor Coustmer service. I Am hungry that Brian. P. Kemp, DavyD. L. Mincey, Nathen Deal, Paul Howard aint Nothing But Corruption. This Need to STOP Now!!

J.C.K.G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